Implementing the "At Risk" Children's Program

The new "At-Risk" Children's Program to serve children and adolescents with Serious Emotional Disturbances is being implemented through a collaborative effort of the Divisions of MH/DD/SAS and Social Services, and the Department of Juvenile Justice and Delinquency Prevention.

New legislative guidelines will help **integrate the system, eliminate redundancies, and provide a more responsive care system** for "At-Risk" children and their families.

SUCCESS =

providing appropriate community-based services to prevent inappropriate placements to targeted populations.

INTENT

The legislature mandated these changes with the intent of serving a broader group of children than were served through the former Willie M. Program and the Eigible Violent and Assaultive Children's Program.

GOAL

Success in this program will be our collective ability to divert children from going into DSS custody, Training Schools (Youth Academies), and State Hospitals inappropriately because they could not receive community-based mental health services.

BACKGROUND

1. In July of 2000, the North Carolina Legislature created:

- At-Risk" Children's (ARC) program, a new funding category for children with serious emotional disturbances and
- the *Children's Residential Treatment Program* – aimed at increasing the amount of available funding for residential treatment for children and youth with serious emotional disturbances

2. The former Willie M. program was dissolved, eliminating the services entitlement along with that program's infrastructure and grievance procedures.

3. The legislature mandated funds for the group of children who were served through the former Willie M. Program/Eligible Violent and Assaultive Children's Program.

4. The legislature mandated Memoranda of Agreement (MOA) at the local and State levels between the Department of Health and Human Services/ Area Mental Health Programs and both the Division of Social Services and the Department of Juvenile Justice and Delinquency Prevention.

MEMORANDA OF AGREEMENT (MOA)

Memoranda of Agreement (MOA) at the local and State levels will be the basis for interagency cooperation and collaboration through local Community Collaboratives to deliver comprehensive mental health services to children.

Each party is required to sign the local level MOA prior to the release of funds to the Area Programs for the new program. MOAs will be refined each year and will require new signatures.

SOC APPROACH
one team
one plan

Consistent with a System of Care approach, our goal is to establish one core service team and one comprehensive service plan with each participating child and family to reduce duplication and increase access to and integration of services.

SYSTEM OF CARE APPROACH

This new program will use a System of Care (SOC) treatment approach. A System of Care is a comprehensive spectrum of mental health and other necessary services and supports, organized and coordinated to meet multiple and changing needs of children with specific mental health needs and their families.

Based on two core values, System of Care is:

1. Child- and Family-Centered
   - services are adapted to the child and family's needs
   - services enhance the personal dignity of the child and family
   - child and family are involved in treatment planning and delivery
2. It is Community-Based

   The community is the primary locus of services/supports and decision making.

ROLE OF CHILD AND FAMILY TEAMS (CFTs)

The services delivered to children and their families through the At-Risk Children's program will be planned and coordinated though Child and Family Teams**.** Team members will be front-line agency staff, the family, and other stakeholders directly involved in the treatment of the child and family. The Child and Family Team will work in full partnership with the family to make treatment and service decisions and to deliver those services.

Case Managers and families are the lead members of the CFT.

COMMUNITY COLLABORATIVES (CC)

The Community Collaborative will serve as the body that supports and oversees their community's Child and Family Teams and the development of their local System of Care.

Area Program, DSS and DJJDP staff should work with each other and with families and family support organizations to develop the Community Collaborative. They are encouraged to build upon existing collaboratives.

Responsibilities of the Community Collaborative

The Community Collaborative will:

- oversee and monitor waiting lists.
- develop criteria for prioritizing waiting lists with attention to priority populations.
- evaluate the service needs and gaps of the community.
- recommend ways to bridge service gaps.
- collaboratively share resources and decision-making with the local agencies/providers to ensure an adequate continuum of appropriate services and supports in the catchment area.

Representation on Community Collaboratives

Community Collaboratives will consist of program level decision-makers from local human services agencies, (DSS, DJJDP, Area Programs), private providers, families, family advocacy representatives and other community stakeholders.

must have representation from Area Programs, DSS, DJJDP and families per legislative mandate.

strongly recommended that local schools, Guardian ad Litem Offices, community organizations, the faith community and other interested parties be represented.

STATE LEVEL COLLABORATIVE

A State Collaborative has been developed, comprised of representatives from DMH/DD/SAS, DSS, DJJDP, families, family advocates and other stakeholders. This collaborative will address policy concerns and oversee and serve as a resource to Community Collaboratives to promote success at the local level.

TRAINING

The State will provide ongoing technical assistance and training designed to aid in the statewide System of Care implementation.

The State will organize a series of training programs that will be available to interested and involved parties at the regional level. Training workshops will be open to all SOC representatives. The series will include:

- The Organization and Functioning of Child and Family Teams and Community Collaboratives
- Family/Professional Partnerships in the treatment children who are At-Risk, and their families
- Case Management Training emphasizing the philosophical basis of conducting a Child and Family Team

TRANSITION FROM WILLIE M. TO "AT-RISK"

The ARC Program is **not** the Willie M. Program:

- The ARC Program must serve a much broader population than the Willie M. Program.
- The ARC Program is **not** an entitlement program.

There is a finite amount of At-Risk funding available for services leading to the creation of services waiting lists that will be maintained and monitored by the Community Collaboratives. The Community Collaboratives will work cooperatively to prioritize children waiting for indicated services. Area Programs will participate in the decision-making process; however, the final decision will be made by the Community Collaborative. While a child may be eligible for ARC services, s/he may not receive them due to funding limitations.

Children eligible for Medicaid are entitled to medically necessary services that are funded through that program. However, the program will provide certain services that are not Medicaid funded. These services, although available to all children in the ARC program, are not an entitlement.

APPEALS

The separate appeals procedure that was in place for the Willie M. Program was repealed by the legislature. Area Program, Division and Department appeals policies and procedures remain in effect to deal with Medicaid and non-Medicaid appeals. The Community Collaboratives cannot take on responsibility for or take the place of Medicaid appeals.

- The ARC program will provide clinically appropriate and medically necessary services. Services (including Case Management) delivered through the ARC program must meet the State medical necessity criteria as outlined in the Level of Care document for children's mental health services. Utilization Review/ Management will serve as an integral program component at both the local and State levels and will be based on the Level of Care document. This applies to services billed to Medicaid *or* ARC.
- There will only be **one** rate for a given service delivered through the ARC program. That rate will correspond to the Medicaid rate, regardless of payment source.
- Legislatively-mandated *"Priority Populations"* will given priority status.
- There is no separate appeals procedure for the At-Risk Children's program.

SCREENING AND ASSESSMENT

SCREENING

To comply with the segment of the legislation that calls for behavioral screening of all children at risk for out-of-home placement or institutionalization, and to identify children before they become inappropriately institutionalized, we have initiated screening programs specific to DSS, DJJDP and the Division of Mental Health.

1. Screening Children Involved with DSS

- Children who are in DSS legal custody (regardless of current physical custody) will be screened with a battery of instruments available to the local DSS agencies.
- Other children involved with DSS, but not in custody, may be screened at the local DSS agency's discretion.
- Children who screen positive (i.e., need behavioral health services) will be referred to the local Area Program for the "Preliminary Assessment and Determination of At-Risk Status" process.

2. Screening Children Involved with DJJDP

- When an intake is scheduled with a local DJJDP Court Counselor, there will be a Needs Assessment (developed by DJJDP).
- If a child screens positive , s/he will be referred to the local Area Program for the "Preliminary Assessment and Determination of At-Risk Status process.

3. Referrals through Mental Health

The local Area Program, family, school, community agency or organization, religious organization, private mental health provider or other interested members of the community may, at any time, refer a child for a "Preliminary Assessment and Determination of At-Risk Status."

INFO PACKET

The Family Information Packet should contain mental health information and information from other involved agencies.

PROCESS FOR ALL REFERRALS

Within 30 Days of Referral:

- Complete the "Preliminary Assessment and Determination of At-Risk Status."
- Complete the AOI Part I (Resiliency Assessment) for all children new to the At Risk Program
- Complete the CAFAS for children new to the Area Program.

If the child is eligible, he/she will be assigned an Area Program case manager who will work jointly with the parent/guardian and the referring party to:

- Identify and authorize immediate/priority service needs through an initial service plan.
- Complete an initial crisis plan.
- Initiate the Family Information Packet.
- Develop a plan for convening a full CFT within 30 days.

Within 30 Days of Admission into the ARC Program:

- The Child and Family Team meets, conducts a strengths-based needs/preferences assessment and completes the Outcomes Assessment Instrument (AOI) Part II.
- The Child and Family Team develops a full ARC program Service Plan, including the crisis plan.
- Materials are added to the Family Information Packet.

All children referred for admission into the ARC program must meet the ARC program eligibility entry criteria.

Referral does not guarantee eligibility.

The Area Program is still obligated to serve children/families who are not eligible for the ARC program.

Medicaid services continue to be an entitlement for those who are Medicaid-eligible.

Area Program policies re: treating clients who are insured, uninsured or underinsured will remain in effect.

ELIGIBILITY

Former Willie M. class members will remain eligible for the program up to 18 months (as of July 1, 2000). Their eligibility will then be reassessed per the "At-Risk" eligibility criteria. There is no longer an entitlement for services, so they may or may not qualify for the program when they are reassessed. Services delivered to these children will be subject to the same utilization review that all services in the program receive.

Begin Now

You should begin enrolling children under the new eligibility criteria immediately.

Children and their families who may have already been enrolled in the program will also remain eligible for service for up to 18 months. At that time, their eligibility will be reassessed.

Schedule for ARC Eligibility Re-Evaluation

Children will be re-evaluated annually to determine ARC eligibility.

A child's initial eligibility is valid for up to 18 months from the point at which h/she entered the program.

The child's mental health "Form B" date (i.e., the date of entry into the Area Program) will be the date for re-evaluation.

Form B Date=

the date of entry into the Area Program as recorded on the child's Form B records.

If a child's mental health "Form B" date comes **less** than six (6) months after his date of initial ARC eligibility, re-evaluation by the Child and Family Team can wait until the next year's "Form B" date.

If the child's "Form B" date comes **more** than six (6) months after his initial eligibility date, re-evaluation must occur by the Child and Family Team on the subsequent mental health "Form B" date.

For Example

	Enters AP System ("Form B" date)	ARC Eligible	ARC Re-Evaluation Due
Child A	1-1-01	3-1-01 (less than 6 mos.)	1-1-02
Child B	1-1-01	9-1-01 (more than 6 mos.)	1-1-03

ABOUT PLANNING...

Please refer to the DMH/DD/SAS Records Manual for full explanation of rules regarding Service Plan timing.

The date of initial ARC eligibility for all former Willie M. class members is 7-1-00 and they will need re-evaluation based on the above system and "Form B" date.

DOCUMENTATION

Children in the ARC program will be required to have an annual AOI (Assessment Outcome Instrument) coinciding with the mental health "Form B"/Re-evaluation date.

An AOI will be completed upon admission to the ARC program.

A Preliminary Service Plan should be completed with the referring party and (as possible), the parent/guardian at the time of entry to identify immediate/priority service needs, including case management and a crisis plan,

This plan must be in place before billing can occur.

Within thirty (30) days of eligibility, a more comprehensive plan should be completed with the full Child and Family Team.

If a child becomes eligible more than 30 days prior to his mental health "Form B" date, a full update of the ARC program Service Plan will need to be done on the "Form B" date.

SCHEDULE FOR ARC PLAN

To ensure clinical integrity, ARC program, Service Plans will need to be re-done by the Child & Family Team on the child's mental health "Form B" date, along with the eligibility re-determination and AOI.

The new ARC program Service plan is being reviewed. You will be notified when it is available and it will be posted on the DMH/DD/SAS Web Page.

Part I of the AOI will be used as a Resiliency assessment to help determine eligibility for the ARC program.

If a child is eligible for the program, the AOI Part II will need to be completed within 30 days..

AREA PROGRAM RESPONSIBILITIES

There are many key functions that Area Programs must provide in order to ensure that the ARC Program operates successfully. These include, but are not limited to:

- Staff the local Community Collaboratives.

> Area Programs personnel may chair the groups for up to three months after the March 1, 2001 implementation date to facilitate more rapid start-up. After that time, the role of chairperson must rotate.
>
> The requirement that the chairperson role not be held by an Area Program staff member is due to the need for At Risk services to operate as a collaborative and comprehensive venture in the community rather than a one-agency initiative.

- Develop and submit a yearly training plan to the State Office regarding the Area Program's continuing education needs/ plans and implementation regarding System of Care.
- Oversee the clinical integrity of the treatment.
- Work with the local Community Collaboratives to maintain a services waiting list for eligible children.
- Work with the local Community Collaborative to document the number of children diverted from inappropriate DSS custody, Training School (Youth Academies), or State Hospitals.
- Assume responsibility for reporting the status of the waiting list and the number of children diverted from institutionalization to the State Office within 2 working days (as needed).
- Assume responsibility for relaying budget issues to the Community Collaborative relative to the services waiting list.
- Act as a liaison with the State Office of Child and Family Services in the Division of MH/DD/SAS.
- Ensure that newly ARC-eligible children are entered into the State MIS system.
- Ensure that a notification of eligibility status is sent within 10 working days of the "Preliminary Assessment and Determination of At-Risk Status" to all parents/guardians and referral sources for children and families referred to the program.
- Provide "System of Care in North Carolina Handbook for Parents" as part of a newly-eligible child's Family Information Packet.
- Ensure that each eligible child benefits from a results-oriented Child and Family Team.

STRENGTH-BASED

The ARC program Service Plan should be built around the strengths, needs and preferences of the eligible child and family and utilizing information gathered during the completion of the AOI Parts I and II.

- Ensure that the Child and Family Teams completes the Assessment Outcome Instrument (AOI) in a timely and appropriate manner for each eligible child.
- Ensure that Child and Family Teams complete and update Service Plans in a timely and clinically appropriate manner for each eligible child and his/her family.
- Ensure that each child's eligibility for the " At Risk Children's" Program is reassessed on an annual (first year up to 18 months) basis referencing to his/her mental health "Form B" date.
- Ensure that detailed and functional Crisis Plans are in place and updated at least every 6 months for eligible children and that a copy is given to the eligible child's parent/guardian for the Family Information Packet.
- Ensure that the "Preliminary Assessment and Determination of At-Risk Status" is a joint and collaborative process, completed in a timely manner, i.e., within 30 calendar days.

These functions may all be fulfilled by a System of Care or "At-Risk Children's" coordinator, or may be fulfilled by a variety of Area Program personnel. In either case, each Area Program must ensure that all functions are operating efficiently.

HOW MUCH FOR HOW MANY?

We do not know how many children will meet the new At Risk criteria or whether the allocation of funds will be sufficient to provide appropriate and medically necessary services to all "At-Risk" children/families for non-Medicaid services.

WAITING LISTS

There will be no limit to the number of children who can be determined eligible for the ARC program.

Children who meet the ARC eligibility criteria should be served on a first-come-first-served basis while At Risk funds are available. However, budget constraints may make it necessary to prioritize amongst eligible children if/when At Risk funds run low.

Medicaid-eligible children continue to be entitled receive appropriate and medically necessary services.

The ARC program will fund some specific non-Medicaid billable services. These services will not be considered an entitlement; consequently, the ARC-eligible child covered by Medicaid could still be subject to waiting lists for non-Medicaid covered services due to ARC budget constraints. Therefore, Community Collaboratives must carefully monitor the availability of funds over time in order to develop and maintain waiting lists, track and document any unmet service needs, and make decisions regarding prioritization for services.

PRIORITY FOR FORMER WILLIE M.

Children in the former Willie M. program/EVAC program are automatically eligible for the ARC program through July 1, 2001.

To promote transition and continuity of care to the new program, former Willie M. children who continue to meet ARC criteria will be considered highest priority.

REMEMBER...

ARC is NOT an entitlement program

Services will be provided only as long as funding is available

Waiting lists will be established based on priority population criteria

Community Collaboratives will maintain waiting lists and make decisions based on available resources

PRIORITY POPULATIONS

In order to achieve the legislative goal of diverting children from inappropriate placement in institutions, the ARC program has established "Priority Populations" for necessary services. They are as follows:

Priority 1
Children in the former Willie M. program who were certified as class members prior to January 22, 1998 (see clarification below).

Priority 2
Children who are at imminent risk of being inappropriately placed in DSS custody, Training School (Youth Academy), or State Hospital due to lack of necessary mental health resources.

Children in these groups are to be given priority status for appropriate and medically necessary services by the Community Collaboratives; e.g., ARC funds should not be authorized for children outside the Waiting List while there are children on the Waiting List.

Children in the former Willie M. program will be considered highest priority to promote transition and continuity of care to the new program, but only if they continue to meet ARC Program eligibility criteria and they were certified as class members prior to January 22, 1998. That was the date that the Willie M. program was released from court supervision and became the program for Eligible Violent and Assaultive Children.

Children in the former Willie M. program/EVAC program are automatically eligible for the ARC program through July 1, 2001. After that time, they will need to be re-evaluated for eligibility as per their mental health "Form B" date. They will only be given priority status within the program if they were certified under the lawsuit (prior to January 22, 1998).

IMPLEMENTATION OF THE NORTH CAROLINA SYSTEM OF CARE FOR THE "AT RISK CHILDREN'S" PROGRAM

In order to effectively implement the ARC program, there are some basics that must be addressed and reported (by Area Programs) to the DMH/DD/SAS in a timely manner. These basics will be included in each Area Program's performance agreement beginning in July 2001.

JANUARY 2001

Begin meeting *now* with members of your Community Collaborative in order to prepare for effective implementation of the ARC program. Among the important issues to discuss are:

Membership
Who will chair
Information necessary for effectiveness
How your local process will work
How you will educate each other about your particular roles and/or mandates

Develop a plan to ensure that private insurance, Medicaid or Health Choice are payors of first resort for all eligible children.

By January 15, Submit Area Program's Utilization Review plan to the Program Accountability Section of the DMH/DD/SAS. (Attention Jim Jarrard – Jim.Jarrard@ncmail.net). The plan must utilize the State Mental Health Level of Care Criteria for all "At-Risk" children and all services rendered.

FEBRUARY 2001

By February 1, begin enrolling children (per the processes described previously) based on their CAFAS scores, out-of-home placement risk, DSM IV diagnosis, and Multi-agency involvement. DMH/DD/SAS will provide you with the Resiliency Screening Form (AOI Part I) in the next weeks. When you receive it, please begin completing this form for children being screened for the program and to send the forms to:

Data Operations Branch of the Division of Mental Health
Attention: Latonia Toms
3019 Mail Service Center
Raleigh, NC 27699-3019

Note that the scores on the AOI Part I (Resiliency Assessment) will not be used to determine eligibility until **March 1, 2001.** DMH/DD/SAS will provide explicit instructions as to when and how to begin using these scores to determine eligibility. The forms must be completed and on children screened in order to determine appropriate cut-off scores for eligibility. **Again, use only the CAFAS scores to determine eligibility between now and March 1, 2001.** AOI Part I (Resiliency Assessment) forms for both eligible and non-eligible children should be sent to the above address and copies should be made for Area Programs.

Children who have been deemed eligible during the period from July 1, 2000 until present will continue to be ARC-eligible. They will be subject to the yearly review of eligibility status, as will all children in the program.

By February 1, core members of the local Community Collaborative must be identified and submitted to the State Office of Child and Family Services in the Division of Mental Health. (Attention Ginny Lofton: 919-571-4900, Ginny.Lofton@ncmail.net) The membership **must** have representation from Area Programs, Families/ Advocacy Groups, Local DJJDP and Local DSS Agencies. Additionally, representation should also be sought from local educational agencies, Guardian Ad Litem offices, Public/Private Health Agencies, Community Organizations, Faith Community etc.

By February 1, all Area Programs must submit the name of a program coordinator to the Child and Family Services Section of DMH/DD/SAS. **Please submit the name of your designee to Ginny Lofton at the above e-mail address/ phone number**.

By February 15, local level MOA between Area Programs and local representatives of DJJDP as well as between Area Programs and local DSS agencies must be signed, and annually by July 1 thereafter (content may change). **The signatures will be monitored during Division Audits beginning in February, 2001.**

MARCH 2001

Begin using the AOI Part I (Resiliency Assessment) to determine ARC program-eligibility consistent with processes described previously.

FINANCIAL AND SERVICES REPORTING

Information regarding allocations, budgets, rates and reporting requirements for the ARC Program will be sent under separate cover.

OPPORTUNITY

The Division of MH/DD/SAS, the Division of Social Services, and the Department of Juvenile Justice and Delinquency Prevention are very excited about the new At-Risk Children's Program and the promise it holds for enhancing community based treatment for a broad population of children with serious emotional disturbances and their families in our State. The General Assembly has given us a window of opportunity to begin developing a System of Care that addresses the needs of children and families in an efficient/ effective, and most importantly, humane and family-centered manner. We must all work together in order to succeed in diverting (and clearly documenting these diversions) children from going into DSS custody, into Training Schools (Youth Academies), and into State Hospitals inappropriately, i.e., because they could not receive community-based mental health services.

We look forward to working collaboratively with you, with families, advocacy groups, as well as many others in the community who are interested in the well- being of children and families in our State.

Questions Anyone?

If there are additional questions, please feel free to call or write the DMH/DD/SAS Child and Family Services Section RSMs (Regional Service Managers), the DJJDP Regional Administrators, and/or the DSS Regional CPRs (Children's Programs Representatives). Much more information is to follow.